

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012366

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 77

**FILED MAR 25 1963**

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		c. CITY OR TOWN <b>Browning</b>	
Length of stay in 1b <b>Oct. 5, 1957</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>423 1/2 Clay St.</b>		d. STREET ADDRESS (If outside, give location) <b>None</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>M</b> Last <b>Carter</b>		4. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/72</b>
9. AGE (last birthday) <b>90</b>		10. USUAL OCCUPATION (Give kind of work done during last year of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Frank Moore</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Turner</b>	
14. NAME OF HUSBAND OR WIFE <b>XX</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>XX</b>		17. INFORMANT <b>Ben Carter</b> Address <b>Breckenridge Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bilateral Parotid Gland Abscess</b>		<b>96 hrs.</b>	
DUE TO (c) <b>Sensitivity</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>10-5-57</b> Month, Day, Year <b>3-19-62</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Browning</b> COUNTY <b>Mo.</b> STATE <b>Mo.</b>	
21. I attended the deceased from <b>10-5-57</b> to <b>3-19-62</b> and last saw her alive on <b>3/19/63</b> . Death occurred at <b>12:30</b> <del>12:30</del> <b>A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>R. W. Mainway</b>		22b. ADDRESS <b>Chillicothe, Missouri</b>	
22c. DATE SIGNED <b>3/21/63</b>			
23a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>	23b. DATE <b>3/21/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jenkins</b>	
23d. LOCATION (City, town, or county) <b>Browning</b>		23e. DATE RECD. BY LOCAL REG. <b>Mar. 20, 1963</b>	
24. FUNERAL DIRECTOR <b>Wade Funeral Home</b>		25. REGISTRAR'S SIGNATURE <b>Annalee Taylor</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address Browning

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.